

ISG-Cultural Competency Meeting
March 8, 2006
Meeting Minutes

Attendees: Michael Allison, N. Burton Attico, MD, Kristine Buchanan, Jacquilyn Cox, Victor Flores, Carmen Green, Pam Mason, Gustavo McGrew, John Molina, MD, Teresita Oaks, Gloria Payne, Ramona Quihuiz, Rona Rehman, Kim Russell, Katrina Serna, Suncerria Tillis, Denis Viri, Jill Wendt, Rick Ybarra

MEETING ITEM	SPEAKER	DISCUSSION	ACTION ITEMS
Welcome	Dr. Molina	Dr. Molina welcomed the participants to the March meeting of the ISG Cultural Competency Committee. He thanked everyone for taking time from their busy schedules to attend.	
Review of Minutes	Committee	The group reviewed the minutes. Page 13 in regards to Mr. Flores text, “decision-making authority” was substituted for “authority”.	*Committee reviewed minutes with change. *Minutes will be on website www.azis.gov
Introductions	Committee	Dr. Molina invited the new members, attending for the first time, to introduce themselves.	
Business Items A. ADA Statement B. ADJC Funding for Families	Jill Wendt	Advised the group that there are disability accommodations for anyone who requests them. She also informed the group that the Arizona Department of Juvenile Corrections may have potential funding to parents to participate on any of the Committees associated with the Integrated Services Grant. If you know of any parents, we can provide funding for parental involvement.	
Business Items C. Committee Action Planning: Review and update matrix	Dr. Molina	Stated that the Committee Action Planning Matrix (CAP Matrix) was disseminated at the January 25, 2006 meeting. This document has 6 tasks assigned to this Committee. It will guide the work and our approach to it. It will also define how we approach cultural competency. There were many good ideas from the last meeting. Your background and experience brought forth many opportunities that we may be able to integrated into the tasks of the Committee. In summary, the key issues I defined for myself were: 1) the type of population we wish to approach. This will take into effect the cultural or ethnic background, and the age of population.	

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	Dr. Molina	Your experiences have taken us into these populations and we will be able to define these populations by culture and age. 2) Location – where are these populations located. Urban areas, small cities, big towns, reservations, etc. 3) Existing resources – what is already out there? Federal, state, tribal programs. Grass roots programs. These are going on, and given the complexity of where we want to address these issues, the first step is to define what is out there. With backgrounds as diverse as our committee, we can address this as a matter of information. Outline the programs and areas and use this as a background.	
		<p>Today, we want to look at the actual tasks of the Matrix. There are six of them. They become more specific towards the end.</p> <p><i>Tasks of Cultural Competency Committee:</i></p> <ol style="list-style-type: none"> 1) Support participation of traditionally under-represented families in decision-making, educational, and technical assistance activities. 2) Provide culturally appropriate education materials for parents and youth. 3) Ensure cultural competency and representation on the Task Force and all communities 4) Provide written documentation regarding the interplay of cultural and health care beliefs for children and youth with special health care needs 5) Engage individuals that are representative of the economic, racial, and ethnic diversity of their communities in the Task Force and committees. 6) Develop linguistic proficiency listing that can be used by all agencies for translation. 	
	Dr. Molina	This will help guide us in what we need to do. Beginning with #1, it will help us define who we are looking at and what resources there are. We are coming up on the end of the first year of the three year grant and we have a long road ahead. However, if we address each task completely and specifically, we will have the time (comprehensively), to look at these and how we wish to accomplish each.	

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		What are the comments on how you interpret Task #1? The other columns to the right: Outcome/Performance Measure(s), Strategy, Action, and Timeline; we can discuss later.	
	Ms. Oaks	My current job is involved with partnership development from the outside. From my perspective, “support participation” means that what we will be doing with the task is <u>maintaining partners from minority groups we have right now</u> . It does not tell me how we do outreach to possible partners that we are not aware of. I would like to see “coordinate and support”. To <u>maintain these contacts</u> . How we <u>identify possible partners</u> in the community that we have not contacted as yet.	Add to Task 1 of ISG-Cultural Competency Community Action Plan Matrix (CAP Matrix): 1. Maintain and support current partners from minority groups 2. Identify new minority partners in the communities
	Dr. Molina	To know what is out there first.	
	Ms. Oaks	Yes. The outcome will be to increase the number of agencies. Support means to just maintain what we have. If we say coordinate, identify, or increase the number of agencies that we are contacting or identifying in the community (minority based agencies) that we need to know who they are.	Add to CAP Matrix Outcome of Task 1: *Increase the number of minority-based agencies that are aware of OCSHCN and ISG.
	Dr. Molina	As we identify specific organizations that are already providing services to children with special healthcare needs and their families, we want to identify their projects. The first step may be to identify the specific projects that currently exist out there. We can identify and coordinate with the work they are already doing.	Add to CAP Matrix Task 1: *Identify current projects and possible coordination.
	Ms. Buchanan	With the Sickle Cell Foundation, we actually go out to the schools and do a PowerPoint presentation. It gives children, parents and teachers, nurse, principles, etc. the facts of the disability, what to do and where to go. It empowers them to take action. Because we are a small organization with a minority root, it is harder for us to get into schools to give them information. We would like to advise as many educators as possible, to heighten their awareness of sickle cell.	Add to CAP Matrix Task 1: *Assist Sickle Cell Foundation on outreach to schools.
	Dr. Molina	Do you think it would be helpful to begin to put together a list of existing programs that we know of (either community-based or agency-based), since we have worked in the field?	Add to CAP Matrix Tasks: *Develop list/inventory of existing program projects.
	Ms. Oaks	That is key. If we have a database of agencies and different organizations that work, we will know what programs are existing.	Add to CAP Matrix Tasks: *Create database of existing

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		We will be respectful of what is in existence and to work with that, we will get a better response.	programs.
	Dr. Molina	If I interpret correctly of what the committee should do, one of goals of the committee is to <u>increase participation of families in the decision-making</u> . If a program is already in existence and being administered, how would we increase the participation of parents and families? Begin identifying, like a database, of programs to see how they are working, and then begin looking at how families access these programs. Jackie, is that in alignment?	Add to CAP Matrix Tasks: *How do families access/interact with these programs.
	Dr. Cox	As long as we keep the focus on children with special health care needs, as the grant focuses on that, we will be all right.	
	Ms. Wendt	I have an asset/inventory form that helps organize information, that I can send out to the members. It takes an inventory of what you already know, and puts it in an organized manner. It could help with our communication and organization.	*Jill Wendt to send out “inventory” form to help organize information to committee members.
	Dr. Molina	In taking the basic approach of collecting the resources, how would that translate into outcome measures?	
	Ms. Oaks	Outcomes can be to <u>increase the number of identified agencies</u> or have a database of participating agencies that are already working out there for children with special health care needs. If they are not currently working with special health care needs, a lot of programs are settings where families from the community feel comfortable and have trust. We could <u>outreach for children with special health care needs</u> . With regards to community leaders (<i>translated from Spanish</i>), there are school-based gatherings; in the school, for parents of the students, to address the issues concerning that particular school. That would be a place to start.	*Outcome measure-to increase the number of identified agencies
	Mr. Flores	With regard to inventory and supporting participation, we need to <u>identify the type of families, identify the challenges</u> , what programs are working or not working, the interpretation of the support and how it is applied. We have to make it meaningful to them.	
	Dr. Molina	Inventory goes both way. We can get what the needs are, from their stand-point and also, ours.	*Discuss formal needs assessment of identified agencies.
	Dr. Attico	What we are talking about is a new paradigm. In the past, health systems have determined what will be done. This is the other way, bottom-driven. The users now determine what the system needs for	

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		it to have, and then picking who, and whoever that is, delivering the service.	
	Ms. Oaks	If we make this inventory, we need to have it by location too. We need to map it out (with services defined) for the entire State to see how these services are delivered throughout the state.	*Inventory to include location. *Potential to use geo-mapping.
	Dr. Molina	So far we have: 1) What is out there and who is doing it, 2) inventory of both sides (clients and our own network), 3) Where they are mapped (population and location).	
	Ms. Wendt	Last meeting, a huge piece of the discussion was on the medically under-served based on location, county, city and state.	
	Ms. Tillis	In Health Systems Development, there is a definition for medically under-served for when providers go into populations and areas. You can start with that, and overlay where services are for special populations, to define where services are within certain populations.	*Ms. Tillis to provide Jill Wendt with definition for medically under-served.
	Mr. Ybarra	Are we looking at a geographical area, by city, county or region of what we know are underserved areas?	*Use geo-mapping to overlay MUS.
	Dr. Molina	Do we want to determine areas and map it out? Is it something online? How does it work on Indian Reservations?	
	Ms. Tillis	There are areas designated as medically underserved and they don't count the IHS eligible.	
	Ms. Russell	Outlined that her office is starting to work on how they are going to designate these areas. The Tribes are already designated medically under-served. They used to designate the whole nation but now they take sections and it is difficult to divide areas. Under represented communities within under-represented nations. Geographic, population and how they are designated are all issues.	
	Dr. Attico	Indian programs have historically been under funded for programs. Consider the programs and the population that are typically underfunded, under-served and under-staffed	
	Ms. Russell	How do you work with the under funded population with no resources? The need is there but no resources available.	
	Ms. Oaks	Rural Arizona is like this. The structure is not there within the small programs they do have. We need to come from the communities towards the department in order to do something significant. Go	

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		out and talk to them. Develop partnerships and identify how they can partner together in their communities to develop network systems. Share resources from what is successful in one community to another.	
	Dr. Molina	So the information needs to be provided to us?	
	Dr. Attico	We need to look at the perspective and methodologies primarily for children with special healthcare needs. A successful program for the children, like Sickie Cell, but as they grow into adults they have the same problems but no transition into adulthood.	
	Ms. Wendt	Quality service to children and then not for youth to adult. We have the ISG Parent Action Council and Specialty Services committee that will be addressing the issue of transition to adult programs.	
	Mr. Allison	There is a lot of data on this. Southwest Institute has a lot of data, not on Native American, but they have a good database. There could be collaboration since they are doing similar work.	*Collaboration with SWI
	Group	There was discussion on sources of external information. To identify other sources specific to youth and young children. Look into the communities and agencies that work with specific populations that have no access to support or provide services for children with special health care. Or agencies that work with groups that don't provide direct services but have children (day care system). Rural areas and the agencies that oversee them	
	Dr. Molina	To identify the specific agencies that already are involved with the children. Department of Education, Justice, Behavioral Health. These could help us map it out by agency. We need to educate ourselves to the needs out there. And the inventory that was mentioned could be of ourselves and agencies.	*Identify listing of current state agency programs
	Ms. Wendt	This responds to the first task of the matrix, to support participation of traditionally under represented families in decision-making, educational, and technical assistance activities. To do that task and identify strategies is to <u>collect an inventory on ourselves</u> and agencies. Then address the performance measures of how we are doing it. The first step would be to identify an inventory and I have a tool to organize that.	*JW has organization tool to help develop inventory of existing state program list

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	Ms. Oaks	For that tool and as we collect that data, we need <u>to collect what cultural competency services they provide</u> . Are they offering translation etc.? ADE has created a Medical Home website, through the HeadStart Association, where they have mapped out the medical home in Maricopa County. We can use their model.	*Ms. Oaks to provide JW with ADE model used for Medical Home database
	Mr. Allison	How do we evaluate the tool from the other side? We need to get the information from the bottom-up.	
	Dr. Attico	We must trust and believe the patient (or parent) to be the decision-maker. They will decide what they will do.	
	Mr. Ybarra	The philosophy around a recovery-orientated approach has been driving the whole behavioral health system for years now. It is really consumer driven. Get the real “buy in” from the consumer and family who are supporting the treatment or recommendation. How do we do it? We ask people. Create opportunities for input and create focus groups. Find the people grounded in the community within a geographic area and work with them. We need to get that information and feedback. Create a survey or tool in that setting.	*Survey to get information and feedback from communities. *Need to define methodology.
	Ms. Oaks	There are <u>leaders in the communities to contact</u> . Ask them what the community needs. They have support of the community and are involved with groups. They gather together to solve the issues. We can do our homework and go to the community and ask them what there needs are. We need to sit down with them, in their conditions, and have them tell us what they need.	*Community leader feedback on needs. *Need to define methodology
	Mr. McGrew	Making the contact and bringing them to the table needs trust. They have interactions that are difficult, that they are not welcome or can’t even get in to see the doctor. The continuity of care, building of the trust falls off. We need to get them to feel empowered. Ask the parents how do they feel empowered, and get things done.	*Obtain information from parents on how the system is working.
	Ms. Tillis	It sounds like task #5, “Engage individuals that are representative of the economic, racial, and ethnic diversity of their communities in the Task Force and committees”. Do we want them to take a leadership role? This is where the resources are for building capacity.	*This information can be obtained through contact list.
	Ms. Oaks	They are already community leaders. Build on them since they are out there and they have the trust.	
	Ms. Buchanan	How do we find the person that impacts the community? It’s easy to find the bigger guys. We need to find the smaller groups.	

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	Ms. Oaks	This is what you ask the leaders. It would require us to go into the community. Establish partnerships in the community to get a reflection of what the community needs.	
	Ms. Quihuiz	Go to where the people live. Mr. McGrew mentioned that faith-based organizations are involved.	
	Ms. Tillis	Can work with case managers and case workers that already have contact with the families. Behavioral Health has a lot of initiatives.	*Need to integrate BHS into this committee.
	Dr. Attico	Case managers make the decision based economics and not on needs of the client. It may not be the proper decision at the time. The system works on economics but it shouldn't be the over-riding decision.	
	Ms. Wendt	Behavioral Health creates the tool and the plan to work with the family with cultural language incorporated in it. So the clinician doesn't have a choice-it is on the form. So incorporating the culturally responsive language, they are already exploring that with the family, by design. They associate and acknowledge the cultural piece, and behavioral health is a good example.	
	Dr. Cox	In regards to faith-based organizations and the composition of this committee, you may wish to add these organizations to the research. In many communities, faith-based organizations defines, marshals, and organizes the culture. Part of the grant is looking at school based clinics, who serve 90% undocumented people. And, for example, the question is "where do they go for healthcare". Since there are many barriers with undocumented. Faith-based organizations came in and helped with that. They defined and built systems in those communities by acknowledging and appreciating that particular culture.	
	Mr. Allison	It is very similar with Native American Tribes (on reservation). What time and resources are available. To be effective, we need a dedicated office or person. It's a tribal community who are the service providers to begin with. They will know what data can be collected. It is important to remember that Tribal government has to be aware of everything you are doing. You must touch base with them and also, with Indian Health Services. We need their cooperation and support. Someone will have to visit these people. If we free up some people, we could do it internally. But there will	*Develop list of contacts within various tribal governments and IHS. *Mr. Allison to develop an initial list for review by this committee.

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		need to be phone calls made, etc. With urban communities, we have the Indian Health Service. Off reservation, there are groups and associations out there. We need the community leaders. It's a large commitment on our part. And what will we do with the data once we get it. What is the return and what does/will OSCHCN provide?	
	Dr. Molina	We have unique elements of what needs to be combined to get our results. Foremost, we need trust and that will take time and structure to complete. We want to make it consumer-driven. We do have champions of the community. Do we want to get the consumer information from them? Our commitment is here to make it happen. The biggest challenge is how are we going to gain trust, identify people, make contact with them and bring the information back. After we analyze it, there may be things we can do and then there will be things we cannot do.	
	Ms. Oaks	We have to be clear that once we start making the contacts, what are the expectations that we are going to give them. We must clearly define what we are doing and explain it or we will break the trust.	
	Dr. Molina	We want to make sure we all agree and understand of what we are offering. These are the core issues of a new paradiagm. Before we begin working, let's define what is it that we want to accomplish.	
	Ms. Wendt	Asked for Dr. Cox's feedback	
	Dr. Cox	The focus of this first task is directed at involving the family. It is good to know all the services and where they are available. However, Mr. Allison's point is true, that the information is readily available through a variety of different sources. To satisfy the performance measures that this task covers, the question is "how is the family participating in driving the system". It has two levels. Are they merely a recipient of a service from an organization, or do they sit on a board, etc.? Do they participate in how the organization or group is structured and functions (decision-making)? Then, how do they participate in the decision-making process of the care of their child. Trying to find out what are these roles, how to people get to these roles, and make sure other people continue to fill the roles.	
	Ms. Oaks	In going out to the communities, if we go through the traditional ways, we will not have a good representation of people that are	*Detail plan to contact community members.

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		under-served. The people that are going through the organized structured healthcare, have access to that. If we go through the community network, we will find out more. We need to get to the true community. And once we go out, do we report back to the State? We have to be careful on how we present ourselves.	
	Dr. Cox	Noted that with SBC visits, she stays behind closed doors so people do not feel unduly alarmed about a “state person” being on site.	
	Ms. Tillis	In getting families involved, do we get on another committee or the Task Force under the grant?	
	Dr. Cox	<p>That is one of the tasks, to inter-relate the committees. Much of what OCSHCN does in terms of education and outreach is that empowering piece. We have one department that developed a training module to train the parents and youth to be a self-advocate. One of the things this committee can do is to look at that training module (on website) and see if it is culturally appropriate. Are we training parents in just one aspect or all? It is time to generalize it and get it out to the public. That would be a task that would be very concrete and would have impact on our outreach and training.</p> <p>On a more focused level, you could look at what is already there and what are the barriers that exist now. Why we are not attracting the people to the systems that are in place in there communities.</p>	<p>*Is training module developed culturally appropriate?</p> <p>*Identify a small group to review Parent-Youth Leadership training. Training is 400 pages long, too long to copy for all committee members.</p> <p>*What current barriers are there to existing systems?</p>
	Ms. Tillis	<p>We want to get the grass-roots people and we will need structure to do this. The time and days it will take. Some people are not readily available in the day.</p> <p>JC-Yes, we had a lot of meetings on this. We researched home care services to the severely impaired children. We reached out to the Department of Corrections and incarcerated youth. These people can’t leave their jobs in the middle of day because their income depends on full time work.</p>	
	Ms. Wendt	Convenient time and location. The Parent Action Council and Youth Council have really focused on that.	
	Ms. Tillis	Should we increase participation on those committees?	
	Dr. Cox	It is one of the things that could be done. To increase the level of participation.	

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	Ms. Wendt	There are Community Action teams all over the state. The Hopi team will be coming on soon. We have school districts, parents, people involved in elder care. They are coming together and talking about service coordination for children with special health care needs. The curriculums were developed by youth leaders. We need to look at their curriculums and then enhance the ability of the curriculum. To make sure they take diversity into account. To represent the population, and then ask why the population is not represented in a culturally appropriate way. We have the building capacity capability.	
	Ms. Buchanan	Yes, it is how do you find parents like myself in the smaller communities?	
	Ms. Russell	In my visiting health directors on the reservations, it takes more time, resources and staff. My office, for example, have to address the Native American issues and it is a lot of work. How do you get people to listen? You can tour communities, shake a lot of hands but we have to get them to come to the table. We get parents into our functions by free give-aways and raffles, etc. Ideas such as this. We found out that the people need bus passes, day care, etc. in order to attend any function. And to go outside the network and ask questions as well.	*Reminder that there are grant dollars to facilitate family members participation in grant activities including transportation, respite, childcare.
	Ms. Oaks	<p>We are in the position that we need to link a lot of resources. We can look at the training that is already there and see if the tool or module is culturally competent or not. Creating a simple instrument that makes us question the things before we start a project. When we went out in the community, what did we ask, who did we ask? A simple questionnaire.</p> <p>We need to educate our staff to have these questions in mind before delivering materials. The staff we have is capable but we have to go to the next step. A simple document of how many people contacted and what to ask.</p>	*Simple questionnaire that makes us look at how this is going to outreach non-traditional partners. How will it be received with minority groups?
	Ms. Tillis	What about the foster care system? In communities of color, we have the super-grandmother who is raising a group of kids and they may or may not have any support.	*Include foster care system. Outreach to CMDP and ASK medical directors on ISG Task Force.

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			*UCP Program in Tucson for grandparents
	Dr. Cox	We have the Medical Director for CMDP and the Director of ASK on the Task Force that this committee may be able to outreach to and include them. It is a very under-represented population. We also have a DES representative on the Task Force.	
	Ms. Wendt	Requested Dr. Cox to give a brief overview and update on the Task Force on when they may be expecting information from this committee. Ms. Wendt advised the group that the committee would report to the Task Force.	
	Dr. Cox	The Task Force meets quarterly and the next meeting is May 24 th . We are hoping that there will be reports from each of the committees on the strategies they are undertaking to accomplish their tasks. So by May 24 th , you should have something concrete to report to the Task Force. The Task Force does not have voting capability on what you do, but they want to have input on any activity that reaches into the community. Their task, at the end of three years, is to take all the information and develop a report to the Governor making recommendations on how to better integrate the services for children with special health care needs. The more information you can give them, to formulate your favorite recommendation, would be in everyone's best interest. They will only get quarterly reports from the committees so the responsibility of the committee is to formulate the strategies and recommendations.	
	Ms. Tillis	What is this committee's relationship to the other groups? For instance, task #2, "provide culturally appropriate education materials for parents and youth". You have an Education Committee, so is that committee developing that and bouncing it off us? How is that working?	*Dr Cox to forward that question to the Education Committee to encourage cross-fertilization of ideas and activities.
	Dr. Cox	That committee has not met yet. But it would be very timely to get someone from that committee to sit on this committee or vice versa. It is going to be very much collaborative. We have a lot of educational materials now and the issue is if they are culturally appropriate now to take to different settings and utilize.	

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	Ms. Wendt	Yes, Dr. Molina and I discussed this earlier. We are charged with that responsibility and initially, we would look at what is existing now.	*Review education materials in existence now.
	Ms. Tillis	The Quality Improvement committees are very important. Is that Quality Improvement in the health care setting?	
	Dr. Cox	That committee is mandated by the grant. It has two primary functions: look at the clinical activities going on in the medical home setting, and to monitor and to make sure that the activities undertaken by the committees are following the grant. Medical Home is going live in about two months and there is a small cultural piece in this and I would welcome anyone from this committee to look at it.	*Dr. Cox to provide Ms. Wendt with Medical Home information for the committee to review for cultural appropriateness.
	Ms. Tillis	It is important to map from the quality improvement aspect. Even from the front line staff to patient/provider interaction and the quality of that. We need to look at the consistency of that. Ensure that you are tracking ethnic and racial data so we can see if there are disparities in the way people are being treated.	
	Dr. Molina	That is part of the next step. For the May 24 th Task Force meeting, Jill Wendt and I will take the lead and summarize what we have done so far. Ms. Wendt handed out the Meeting Schedule and advised the group that the committee will have two more meetings before the May 24 th Task Force meeting. We can summarize our results for the next meetings so we can get feedback.	*JW will email 2006 schedule of Cultural Competency Committee Meetings to Victor Flores.
	Ms. Oaks	I would like to suggest that for the next meeting, it may be good for everyone to bring a specific outcome that the group may want to work on.	
	Dr. Molina	I will develop a questionnaire and statement of purpose to help keep us aligned in terms of our general purpose and what we want to do. With the concept of building up trust within the communities, to identify what services are there, what they may be missing, what agencies are servicing them. I will present a draft to the committee.	*Dr. Molina to develop general questionnaire to help align goals.
	Mr. Allison	Raised a concern that the discussion today will do good for other populations but not much for Native American populations. With Native Americans, the IHS is our medical home. By treaty, the	*Need additional discussion on how to involved Native American communities. Possibility to

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		government is obligated to provide services and IHS does that. As it was pointed out, we may be under-funded but it is still there. We don't have some of the problems you would see with private insurance. With this committee, we have the opportunity to have a voice and it is appreciated, but I don't believe that the questionnaire will help the Native Americans populations in need. Systems are different, and if we do these types of programs and oversight, we almost need a separate group/committee for Native American issues.	include members of the Hopi team with this committee.
	Dr. Cox	Within the grant, there was funding for two new Community Teams to be set up in traditionally under-served communities. One team is on Hopi. What this committee may wish to do is to make a recommendation to look a team specific to the Navajo nation, on the reservation, run by the Navajo people. It will help with what Mr. Allison mentioned and also it will fill a component of the grant.	*Specific community team on Navajo Nation.
	Ms. Wendt	Thanked all the committee members for their participation.	
Next Meeting		Tuesday, April 4, 2006 1pm – 3pm Room 345A ADHS Building	